Agenda
Annual 5 Partners Accountability Session
Wednesday, June 6, 2017
8:00 AM – 11:00 AM
Embassy Ballroom, Victoria Inn, 555 Arthur Street West

Strategic Objective: To provide a 2020 Strategic Plan report to our '5 Partners in Health'.

#	Time	Presenter	Item & Purpose	Meeting Notes
8:00 a.m. – 8:30 a.m. BREAKFAST AVAILABLE FOR ALL ATTENDEES				
1	8:30 a.m. – 8:35 a.m. (5 min)	Tracie Smith	Call to order and Introduction.	
2	8:35 a.m. – 8:40 a.m. (5 min)	Tracie Smith	Patient and Family Advisor Perspective: Video	
3	8:40 a.m. – 8:45 a.m. (5 min)	Jean Bartkowiak	Welcome and Overview of the Session.	
4	8:45 a.m. – 9:00 a.m. (15 min)	Stewart Kennedy	***Strategic Direction:*** **Comprehensive Clinical Care** • Patient Flow Optimization: The Urgency of Capacity Management.	
5	9:00 a.m. – 9:10 a.m. (10 min)	Tracie Smith	***Engagement Activity:*** Managing Expectations	
6	9:10 a.m. – 9:20 a.m. (10 min)	Ron Turner	***Strategic Direction:*** **Patient Experience** • Patient Transitions: Patient Oriented Discharge	
7	9:20 a.m. – 9:25 a.m. (5 min)	Tracie Smith	***Strategic Direction:*** **Indigenous Health** • Partnerships	
8	9:25 a.m. – 9:30 a.m. (5 min)	Tracie Smith	***Engagement Activity:*** Add, change, delete	
Health Break 9:30 a.m. – 9:45 a.m. (15 min)				

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Annual 5 Partners Accountability Session
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#	Time	Presenter	Item & Purpose	Meeting Notes
9	9:45 a.m. – 9:55 a.m. (10 min)	Darcy Price	***Strategic Direction:*** **Acute Mental Health** • Strategy for Substance Abuse/ Opiod Addictions Management	
10	9:55 a.m. – 10:05 a.m. (10 min)	Tracie Smith	***Engagement Activity:*** Our Hospital's role with patients that present with substance use issues.	
11	10:05 a.m. – 10:15 a.m. (10 min)	Susan Veltri – Geriatric Care Coordinator RN	***Strategic Direction:*** **Seniors' Health** • Frail Seniors Pathways: Right Care, Right Time, Right Place	
12	10:15 a.m. – 10:25 a.m. (10 min)	Tracie Smith	***Engagement Activity:*** Supporting frail seniors to successfully manage.	
13	10:25 a.m. - 10:45 a.m. (20 min)	Arlene Thomson	***Strategic Direction:*** **Comprehensive Clinical Care** • Cardiovascular Surgery Program: Update	
14	10:45 a.m. – 10:50 a.m. (5 min)	Tracie Smith, Jean Bartkowiak	Re-Cap and Closing Remarks.	

Appendix:

Item # 4.0 Comprehensive Clinical Care: Patient Flow Optimization

Item # 6.0 Patient Experience

Item #7.0 Indigenous Health: Partnerships

Item # 9.0 Acute Mental Health

Item # 11.0 Frail Seniors Pathways: Right Care, Right Time, Right Place

Item # 13.0 Comprehensive Clinical Care: Cardiovascular Surgery Program

For Information:

Summaries:

- 2020 Strategic Plan Updates

2020 Strategic Plan: 5 Partner Annual Accountability Session – Year 3

Patient Flow Optimization: the Urgency of Capacity Management

Dr. Stewart Kennedy
Executive Vice President, Medical, Academics & Regional Programs

Thunder Bay Regional Health Sciences Centre

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Comprehensive Clinical Care

Enhance the delivery of our clinical services.

Strategic Initiative

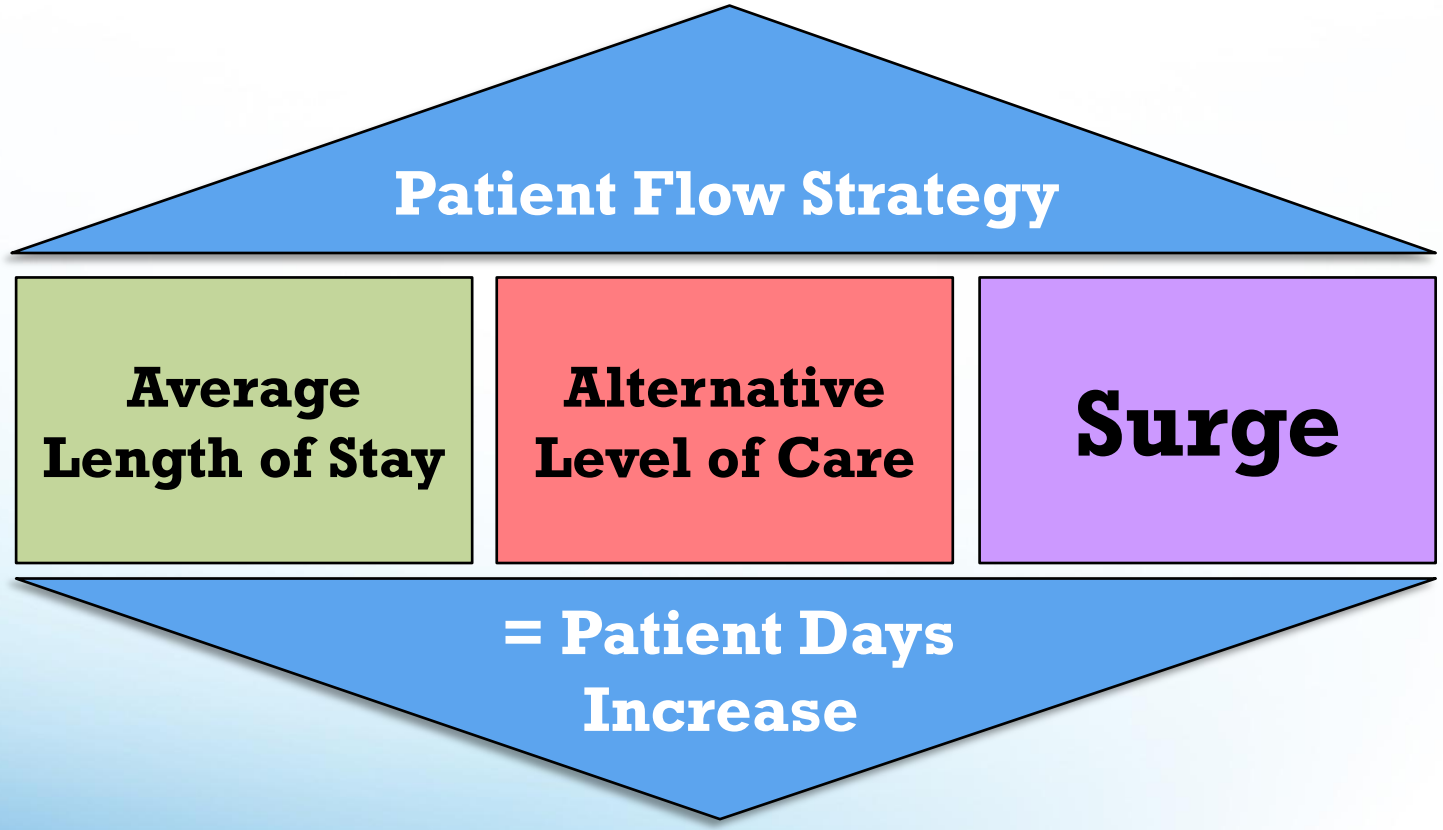
GOAL

- Enhance access to clinical services supported by patient flow efficiencies

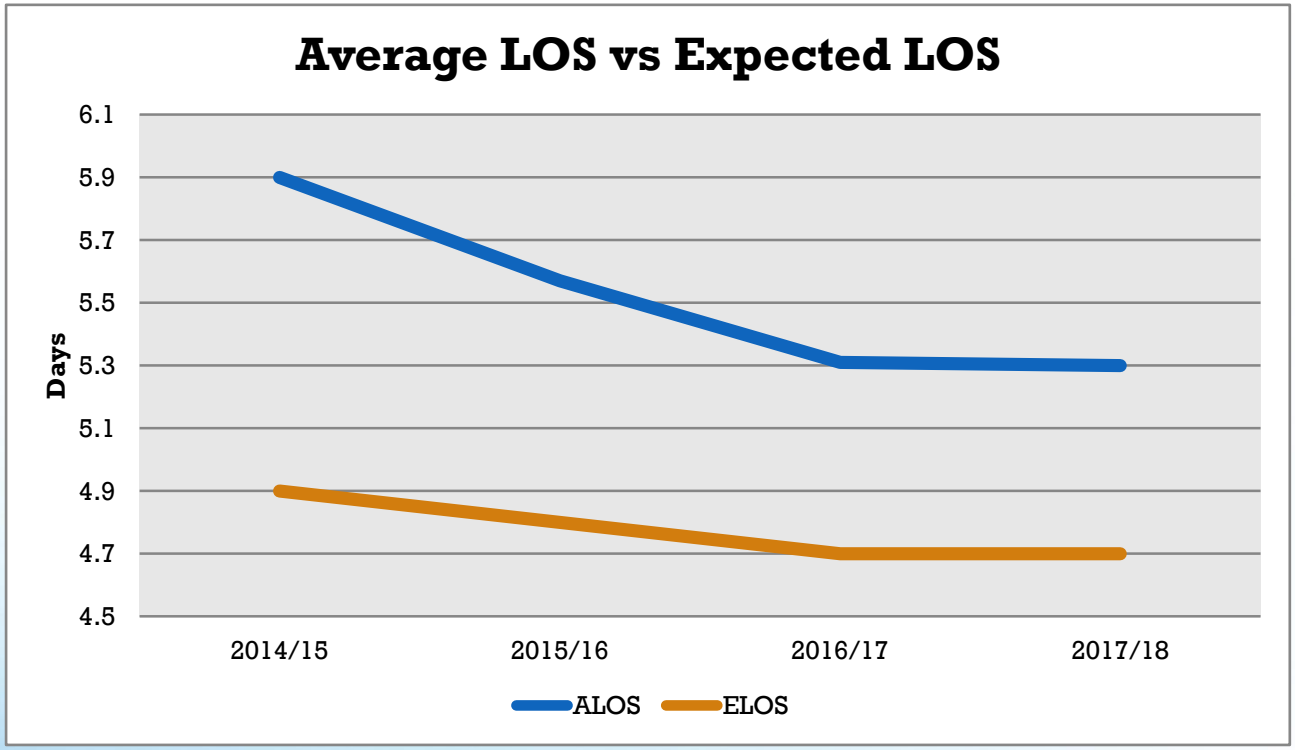
OBJECTIVES

- Improve internal patient flow efficiencies
- Advocate and demonstrate the need for additional health systems capacity

Patient Flow Strategy: Areas of Focus



2017/18 Challenge: Average Length of Stay



Average Length of Stay Barrier to Access

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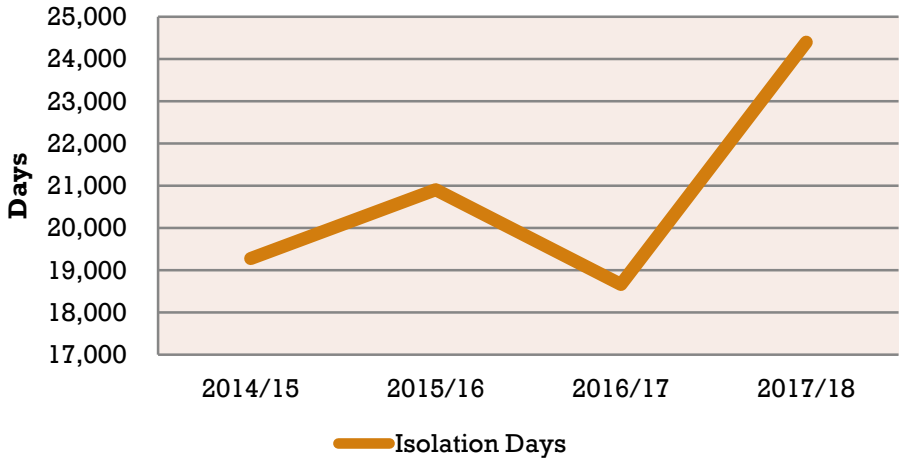
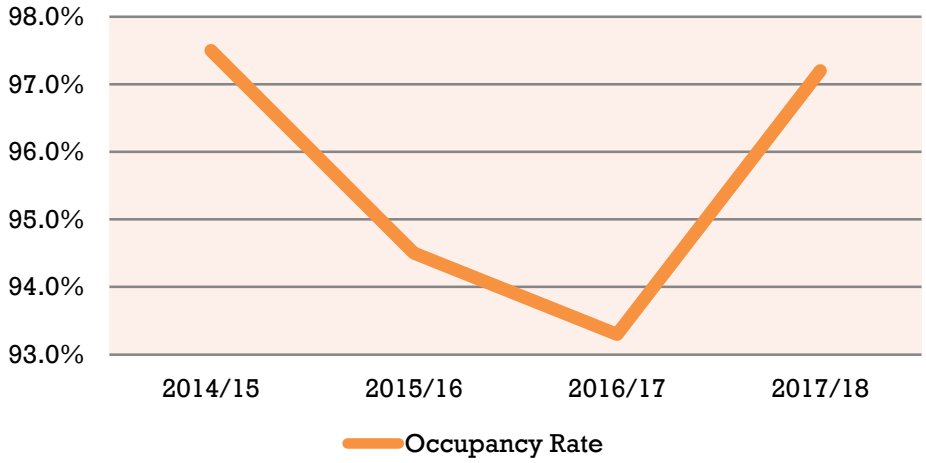
2017/18 Activity & Challenge: Alternate Level of Care Patients

- Hogarth Riverview Manor centre of excellence DELAYED June 2017
- Hospital Elder Life Program –'HELP'
- Frail Senior Pathway Project
- Geriatric Care Coordinator in Emergency Department
- Provincial Response to Alternative Level of Care - 2000 LTC beds

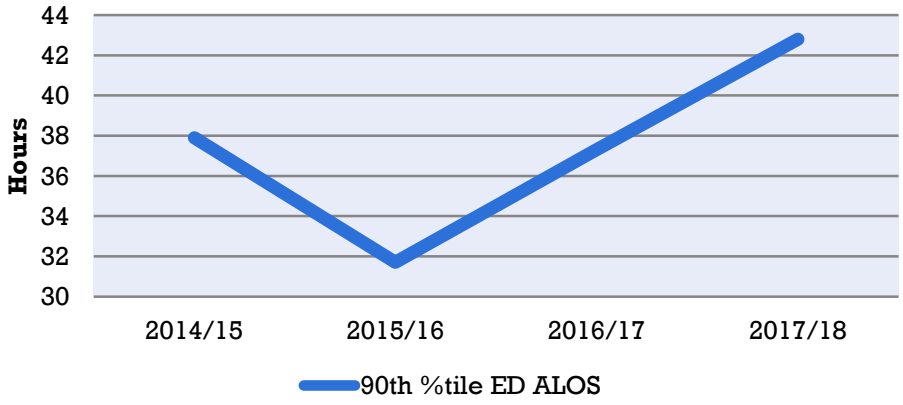
Isolation Days



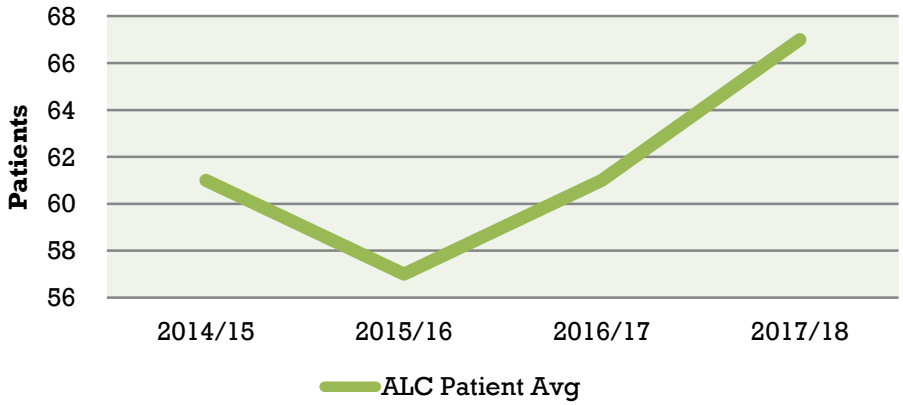
Occupancy Rate



90th %tile ED Admitted Length of Stay



Patient Average - Alternative Level of Care




SUN ROOM
CLOSED
BEING USED AS
PATIENT
ROOM

2017/18 Activity & Challenge: Overcapacity

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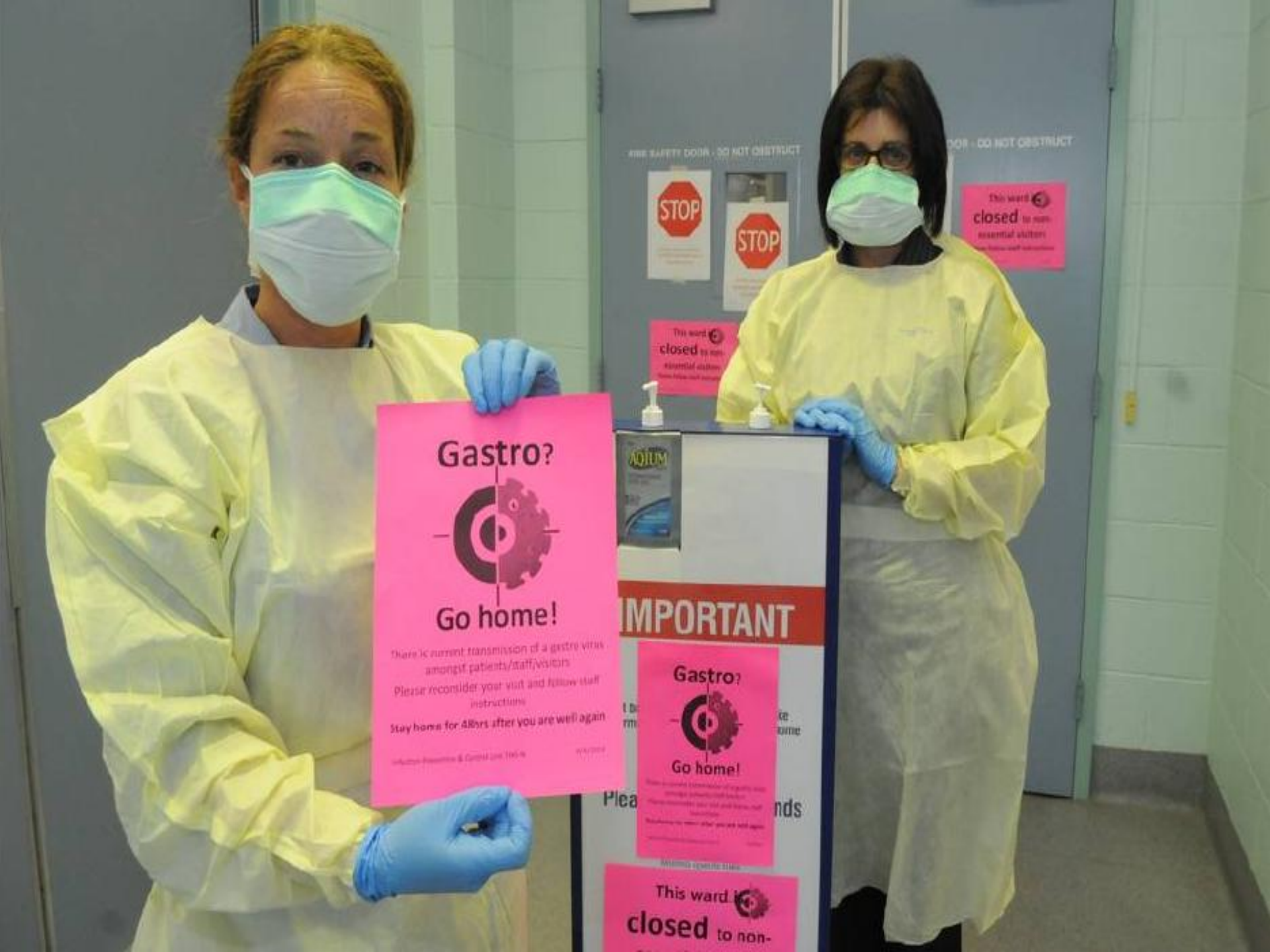
Enhance the delivery of our clinical services.

Risks

RESEARCH

The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments

Peter C Sprivulis, Julie-Ann Da Silva, Ian G Jacobs, Amanda RL Frazer and George A Jelinek


Gastro?
Go home!
There is current transmission of a gastro virus amongst patients/staff/visitors
Please reconsider your visit and follow staff instructions
Stay home for 48hrs after you are well again
STOP
STOP
AQIUM
IMPORTANT
Gastro?
Go home!
This ward is closed to non-

NURSES ARE OVERWHELMED

Opportunities

Internal Efficiencies:

- OHA Strategies to improve Hospital Capacity
- Enhance Technology - Physicians, Bed Management, Infection Control
- Engage & Support Staff & Physicians

Advocacy:

- Hogarth Riverview Manor (HRM) Transitional Care Beds extended.
- New Short Term Transitional Care Funding $1.6 mil for System Partner Collaboration


D7
D8
D9
D10
stryker
stryker

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PATIENT FLOW

ONE QUESTION PER TABLE

Question 1: What measures would make transfers within the Hospital more comfortable?

Question 2: What initiatives will enhance hand hygiene participation by patients, families and visitors?

Question 3: What measures would make waiting in the Emergency Department more comfortable?

2020 Strategic Plan: 5 Partner Annual Accountability Session – Year 3

- **Patient Experience**

Patient Transitions: Patient Oriented Discharge Summary

Ron Turner, Interim Executive Vice President, Inpatient Programs

Thunder Bay Regional Health Sciences Centre

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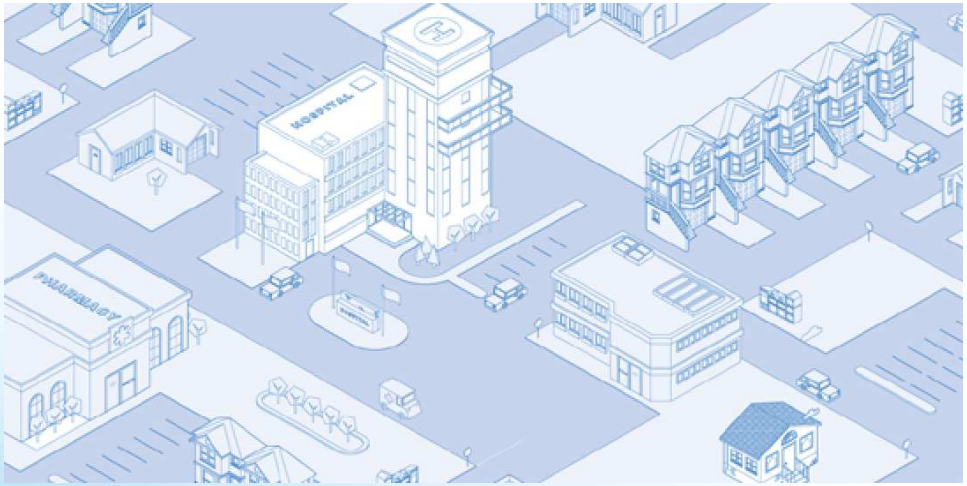
Patient Experience

Enhance the quality of the patient experience.

Why

Discharge from hospital can be a vulnerable transition for patients. Despite this, many hospitals are not using patient-centred discharge summaries; discharge tools that are easy for patients to understand and act on upon leaving the hospital.



What is PODS

The Patient Oriented Discharge Summary (**PODS**) is a simple tool that arms patients with the key pieces of information they need in order to effectively manage their health after a hospital discharge:

S igns and symptoms to watch out for

M edication instructions

A ppointments

R outine and lifestyle changes

T elephone numbers and info to have handy

PODS was developed with the help of patients and families, and is being adopted in hospitals across Ontario.

More Evidence

- The **PODS** is designed according to best practices in patient education.
- The **PODS** also gives consideration to the cognitive processes involved in information processing and retention by including white space for patients to take their own notes. Note taking has been shown to improve information recall.

PODS Design Elements to Support Transitions:

The PODS

DeSign eleMenTS:

- ✓ Large font
- ✓ Clear language
- ✓ Directed to the patient
- ✓ Distinct, easy to follow headings
- ✓ Point form
- ✓ Whitespace for note taking

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Congestive Heart Failure (CHF) Patient Oriented Discharge Summary

Place Patient Label with Barcode Here

I came to the hospital on _____ and left on _____.

I came to the hospital because I had Congestive Heart Failure.

Medications I Need To Take:

My medication list has been provided and explained to me ☐

My prescriptions have been faxed to _____ Pharmacy ☐
(complete with name of pharmacy)

Changes In My Routine:

Exercise	Breathing and walking exercises as directed by your health care team.
Smoking	QUIT Smoking.
Flu Shot	Get one every year.
Diet	Follow a reduced salt diet. Call EatRight Ontario if you have questions about your diet (1-877-510-5103).

Outpatient Appointments:

Family Care Practitioner: _____
Cardiologist: _____
Heart Failure Clinic: _____
Cardiac Rehab: _____
North West LHIN Home and Community Care: _____
Other: _____

My Notes: _____

_____

_____

_____

_____

_____

Patient/Family Signature: _____
Nurse Signature: _____

Guidelines for Use:
1. Primary nurse to complete and review with patient prior to discharge
2. Nurse to photocopy Page 1 only and place in patient chart
3. Hardcopy to be given to patient at discharge

Place Patient Label with Barcode Here

How I Might Feel and What to Do:

Every Day!
- Weigh yourself in the morning **before** breakfast.
- Keep the total amount of fluids you drink to 6 to 8 glasses each day (6 to 8 glasses equal 1500-2000ml daily).
- Take your medicine exactly how your Doctor told you.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat foods that are low in salt or salt-free.
- Balance your activity and rest periods.

Green Zone: All Clear - This zone is your goal! • No shortness of breath. • Usual amount of swelling in legs. • No weight gain. • No chest pain, pressure or discomfort. • No change in usual activity.	**Your symptoms are under control. Go to your scheduled Doctor/NP/Heart Failure Clinic appointments. Check your feet, ankles and legs for swelling.**
Yellow Zone: Caution - This zone is a warning! • A weight gain of 2-3 pounds in 1 day, or 5 pounds in 1 week. • Increased number of pillows to sleep. • Increased swelling in feet, ankles and legs. • You are feeling tired or light headed. • Shortness of breath or cough with activity.	**You may need to change your medicines Call your Doctor/NP/Heart Failure Clinic for instructions.**
Red: Emergency - This zone means act fast! • Weight gain of more than 5 pounds in 1 week. • Dizziness or falling. • Waking at night due to shortness of breath. • Shortness of breath at rest, chest tightness or wheezing. • You are having trouble thinking clearly or are feeling confused. • You have fainted.	**Call your Doctor/NP/Heart Failure Clinic *today* to report symptoms and request an appointment.** ******CALL 911 if you are having chest pain******

Where To Go For More Information:

Heart and Stroke Foundation: Heart failure
Go to: https://www.heartandstroke.ca/heart/conditions/heart-failure

Canadian Heart Failure Network
Go to: http://www.chfn.ca/

How

- ✓ **PODS** has been standardized, and self populated when appropriate.
- ✓ **PODS** will be incorporated into the electronic order sets where possible.
- ✓ **PODS** should not be additional work as it is meant to replace the current Patient Discharge Record.

The Benefits of PODS

- Patients and caregivers will consistently receive the information that they need to know in order to effectively manage their health the moment they leave the hospital.
- **PODS** contains information most relevant and actionable for patients, presented in an easily understandable and usable form.
- **PODS** will help structure the conversation with patients, making it efficient to get the most critical information across.
- **PODS** is also a communication aid that could be used as part of a teach-back process.

When and Where

- **PODS** has been implemented on the Adult Mental Health and Medical Inpatient Units at TBRHSC, and will be spreading across the Maternal Newborn, Paediatrics and Inpatient Surgical Units in the upcoming months.
- There are currently 13 discharge diagnosis specific **PODS**, and 2 generic **PODS** available to support patient discharges.

PODS?

PATIENT ORIENTED DISCHARGE SUMMARY

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Patient Experience

Enhance the quality of the patient experience.

2020 Strategic Plan: 5 Partner Annual Accountability Session – Year 3

Tracie Smith
Indigenous Health Director Leader

Thunder Bay Regional Health Sciences Centre

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Indigenous Health
Enhance culturally appropriate care.

Strategic Initiative

- **Goal 1:**
- **Provide care that improves self-management, access, experience, and transition to home for Indigenous patients.**

Activities

- Additional discharge planning resources from Dilico Anishinabek Family Care
- New protocol agreement with Dilico Anishinabek Family Care for Child Welfare Services
- Prevention & Screening capacity building with First Nation communities
- Expanding the Regional Critical Care Response program to First Nations
- Anishnawbe Mushkiki – building ties to address gaps

Accomplishments

- Indigenous Community Activity Planning Group
- Indigenous Health & Reconciliation Steering Committee
- Senior Director, Indigenous Collaboration
- Pilot Project proposal

Moving Forward – Year 4

- New Strategic Objective:
- Formalize partnerships to secure the resources necessary to initiate by the end of 2019/20 a pilot project to provide territory-specific discharge planning for Indigenous patients.
- Your input: Add, Change, Delete

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INDIGENOUS HEALTH

OBJECTIVE: Formalize partnerships to secure the resources necessary to initiate by the end of 2019/20 a pilot project to provide territory-specific discharge planning for Indigenous patients.

2020 Strategic Plan: 5 Partner Annual Accountability Session – Year 3

Acute Mental Health - Enhance acute mental health service

Presenter: Darcy Price
Strategic Direction Senior Leader: Ron Turner

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Acute Mental Health
Enhance acute mental health service.

Strategic Initiative

Direction

- **Acute Mental Health - Enhance acute mental health service**

Goals

- **Adopt attitudes and behaviours that recognize mental health as an integral part of the delivery of comprehensive acute care services.**
- **Enhance the delivery of mental health care to patients outside of mental health services**
- **Collaborate with system partners and appropriate governing agencies to develop and enhance transitions in care**
- **Enhance the delivery of acute mental health care within mental health services**

Activities

- Continue with the RESPECT Initiative
- Consultation Liaison Pilot Role out with other units
- Continued Recruitment of Psychiatrists
- Finalize a formal governance structure for psychiatrists
- Role out updated Admission Assessment that includes Mental Health Screening
- Comprehensive service- funding request for Child & Adolescent Psychiatry APP to service CAMHU full time has been submitted

Accomplishments

- Mental Health Emergency Services Proposal complete and ready for LHIN discussion
- Creation of Checklist for Safe and Quiet Rooms
- Currently at 83% compliment for Psychiatry
- Coordinated Care with SJCG primary providers complete

Moving Forward – Year 4

- **With the assistance of internal and external stakeholder we have begun to examine *Substance Use* and the underlying impact on patient care.**
- **The working group is asking for input on our role as an Acute Care Hospital.**

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ACUTE MENTAL HEALTH

Question 1: As an acute care hospital, what is our role with patients that present with substance use issues?

1. Acute management and stabilization
    - Medical
    - Psychiatric
    - Social
    - Initiate meds
    - Transitional pain service (TPS)
    - Withdrawal management
2. Referral
    - Pathways for referral
3. Educate
    - Internal
    - External/regional
    - Regarding prescribing, stigma
4. Resources
    - Advocacy
    - Pathways

Question 2: Which best captures the work we need to do to meet the needs of the patient population?

Please circle one option:

1. **Develop evidence informed acute care for addictions.**

2. **Develop community connections and pathways for individuals with complex addiction issues.**

2020 Strategic Plan: 5 Partners' Annual Accountability Session – Year 3

- **Frail Seniors' Clinical Pathway**

Susan Veltri, Geriatric Care Coordinator, RN
Dr. Stewart Kennedy, EVP, Medical, Academics & Regional Programs & Regional VP, CCO

June 6, 2018

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Seniors' Health
Enhance the care provided to an aging population.

Frail Seniors' Clinical Pathway

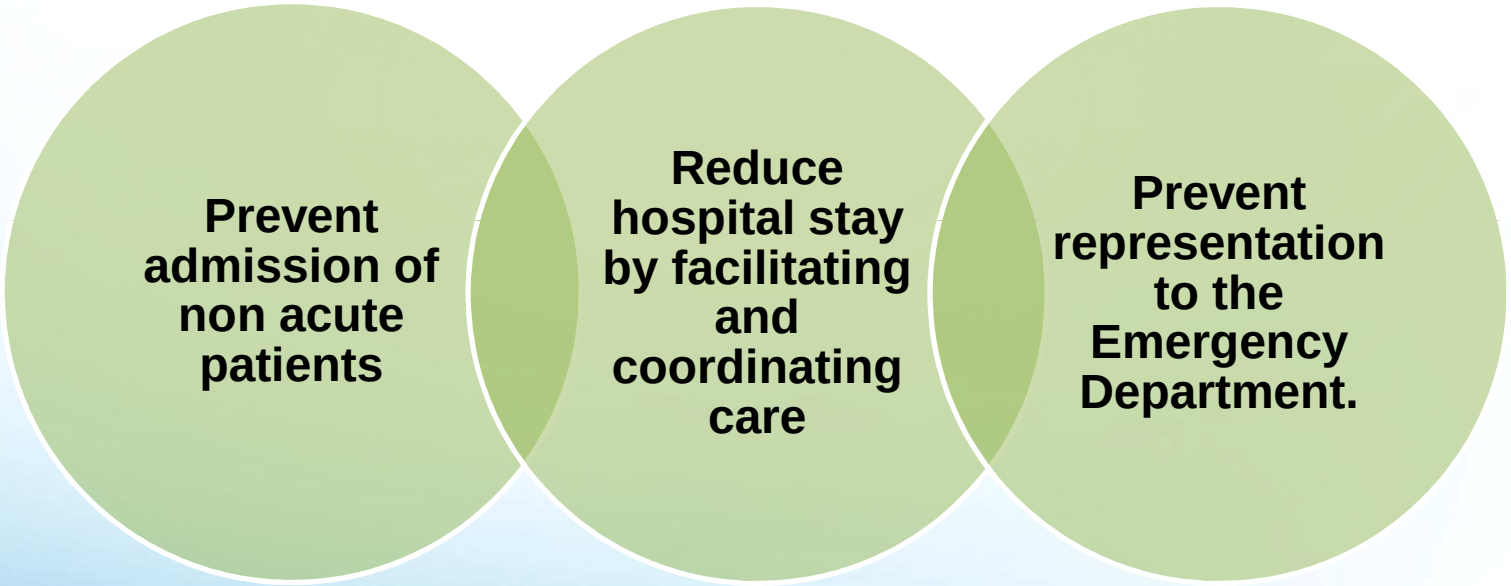
What is the *Frail Seniors' Clinical Pathway* project?

- ***Rapid assessment*** **of at risk elderly patients**
  - Use of *standardized tools* that start early, upon presentation to acute care
- **Promotes *Senior Friendly Care***
- ***Facilitates referrals*** **/ consults to other services or health professions**
- **Supports care *across the continuum***

Frail Seniors' Clinical Pathway

What are the primary goals?

- To collaborate with other team members & community partners to:

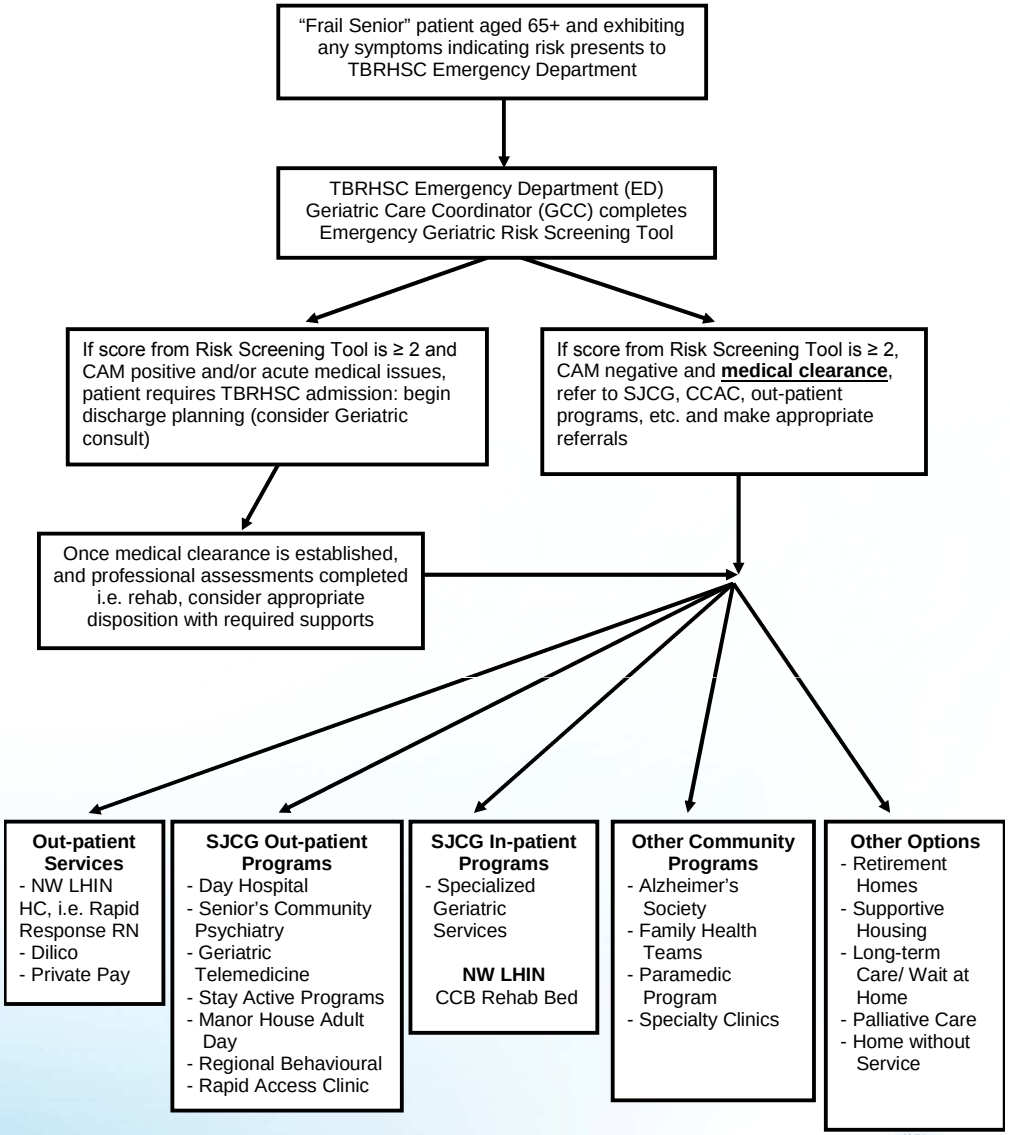


Inclusion/Exclusion Criteria

Inclusion
> 65 years old & residing at home
At least one risk factor: • Declining function • Difficulty completing activities of daily living
Multiple/frequent Emergency Department (ED) visits and/or admissions to acute care
Patients who screen as high risk on presentation to the ED

Exclusion
Residents of Long Term Care
Refusal by patient, family member or physician

Frail Seniors' Clinical Pathway Flow Map



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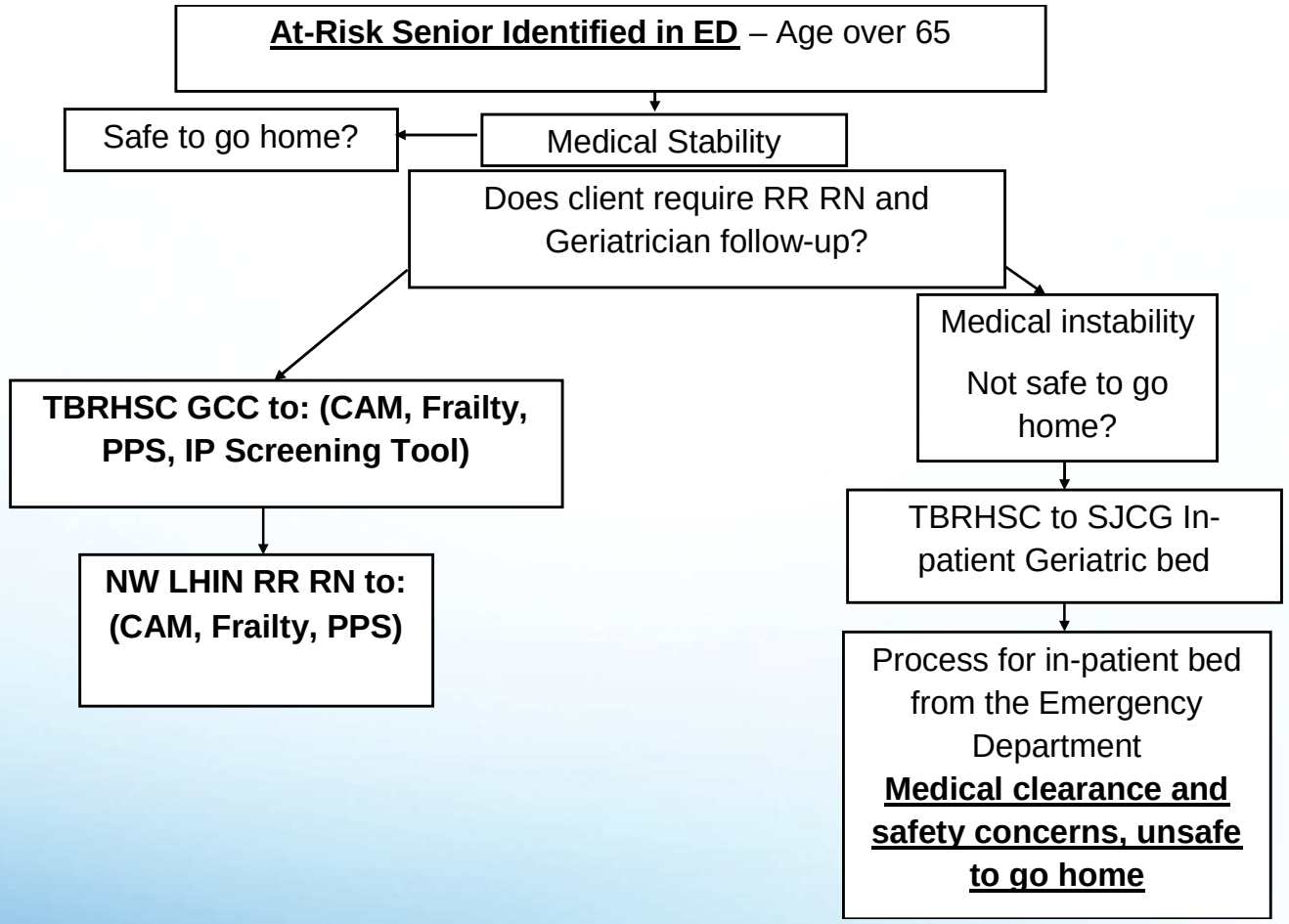
Seniors' Health

Enhance the care provided to an aging population.

Rapid Access Algorithm



2017/18 Frail Seniors' Data

Patients screened	1960
Patients assessed	487
Admissions avoided	200
Rapid access trial	32
Follow up calls completed	302 patients

For assessed patients, the *Average Length of Stay* to ALC/Discharge – 3.32 days

Accomplishments

- Electronic Health Record updated with Geriatric Assessment Intervention & Order Entry
- Education on the care of the elderly for TBRHSC staff & volunteers
- Preoperative delirium screening for seniors presenting with fractured hips and chronic illness
- Building capacity to include other Health Care Professionals in the Senior Friendly Process
- Family Care Grant allocation to support seniors admitted to hospital
- Patient Oriented Discharge Summary (PODS) for Delirium & Frail Seniors

Comments/Feedback

- Patients and families felt supported during transitions
- TBRHSC staff appreciate improved care processes and access to specialty resources
- Positive feedback regarding follow-up phone calls and post discharge supports
- Improved patient outcomes supported by collaborative model
  - e.g. TBRHSC ➡ NW LHIN HACC ➡ SJCG

Moving Forward – 2018/19

Explore opportunities to:

- Provide Geriatric Care Coordinator services 24/7
- Increase resources to support patient care in the home setting
- Provide enhanced senior focused care to admitted patients to minimize de-conditioning or other hospital acquired symptoms, and to decrease length of stay

Questions?

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Seniors' Health

Enhance the care provided to an aging population.

5 Partners in Health

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SENIORS' HEALTH

Question 1: What services are needed most by frail seniors to support them to successfully manage in the community?

Question 2: Refer to the top 2 services. How do we partner with other service providers to connect frail seniors to the services?

2020 Strategic Plan: 5 Partner Annual Accountability Session – Year 3

- Northwestern Ontario's Cardiovascular Surgical Program

Arlene Thomson
Senior Director, Cardiovascular Surgery Implementation

Thunder Bay Regional Health Sciences Centre

UHN Peter Munk Cardiac Centre

Comprehensive Clinical Care

Enhance the delivery of our clinical services.

Vascular Program Growth

Dr. Mary MacDonald & Dr. Elrasheed Osman

Thunder Bay Regional Health Sciences Centre

UHN Peter Munk Cardiac Centre

Comprehensive Clinical Care

Enhance the delivery of our clinical services.

Rapid Access Vascular Examination (RAVE) Clinic

GOAL: Reduce the Amputation of Limbs

- New in 2018
- Provides speedy access to vascular screening for patients (non-healing wounds)
- Multidisciplinary care model adds value for patients (Wound Nurse, Vascular Surgeon, Vascular Ultrasound Technologist)
- “One-Stop” approach

Partnership & Quality

- UHN and TBRHSC share a joint Medical Program Director
- Dr. Barry Rubin, UHN, leads our quality improvement activities
- February, 2018 presented 1st year's data from the Vascular Quality Initiative (VQI) to TBRHSC Board

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UHN Peter Munk Cardiac Centre

Comprehensive Clinical Care

Enhance the delivery of our clinical services.

Cardiac Surgery Development: Perfusionists

Alex Brazeau & Scott Longridge

Thunder Bay Regional Health Sciences Centre

UHN Peter Munk Cardiac Centre

Comprehensive Clinical Care

Enhance the delivery of our clinical services.

CCHL Award: Value-Based Healthcare

- Canadian College of Health Leaders (CCHL) honours an organization/ team that is deliberate in **changing the way that care is delivered**, resulting in improved patient outcomes.
- Value-based…. means that patients are being **optimally cared for** at the right time, in the right setting and at the right cost.

Thunder Bay Regional Health Sciences Centre

UHN Peter Munk Cardiac Centre

Comprehensive Clinical Care

Enhance the delivery of our clinical services.

Capital Project

- **Estimated cost $32.7M**

- **Preliminary project scope:**
  - 14 new ward beds
  - OR renovations +1 hybrid Operating Room
  - New Vascular Lab (noninvasive diagnostic)
  - Expansions to Biomedical and Supply/Processing
  - Renovation to create an Acute Cardiac Unit (CCU)

Thank you

- Any Questions?

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Strategic Plan 2020

2020 Strategic Plan Updates
Year Three

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Strategic Plan 2020: Annual Accountability Session – Year 3
Comprehensive Clinical Care – Enhance the delivery of our clinical services

Adopt the Ontario Chronic Disease Prevention and Management framework.
The Hospital has completed a self assessment and determined that the 8 elements of the CDPM Framework are met through current activities. The Hospital designs care to support prevention and management of chronic diseases in the 8 elements: Health Care Organizations, Delivery System Design, Provider Decision Supports, Information Systems, Personal Skills and Self-Management Supports, Healthy Public Policies, Supportive Environments, Community Action.

Enhance access to clinical services supported by patient flow efficiencies.
It was a challenging year to progress internal patient flow efficiencies. Two examples of improvements relate to:

1. The Emergency Department and 1A In-Patient unit are trialing a new electronic transfer form, which will improve the timeliness and accuracy of patient information in nurse handover of care. All units will adopt the form when the pilot is complete.
2. A quality improvement 'Design Event' was held with the physiotherapy & occupational therapy staff to improve issues related to interprofessional team collaboration and communication. Solutions were developed including: daily team meetings to prioritize patients and level workloads between staff, and better transfer of information to nurses and physicians.

Significant efforts focused on collaborating with system partners to advocate for additional capacity for alternative level of care patients.

Develop formal partnerships to deliver comprehensive clinical services that support care in the appropriate location.
The Regional Orthopeadic Program is established. Program heads are engaging Neurosurgeons to explore the integration of non-instrumental spinal surgery. The goal is to provide consistent service across the four dedicated regional site hospitals.

The Emergency Department leadership engaged the Northwest Community Health Center (NWHC), St. Joseph's Care Group's Rapid Access Addiction Medicine (RAAM) clinic to care for patients with addictions requiring long-term intravenous antibiotic therapy via peripheral intravenous central catheters (PICC) in the community.

The Hospital established a Strategic Alliance Agreement with the Nipigon District Memorial Hospital (NDMH). This alliance enhances the regional approach to health care and improves both effectiveness and efficiency in administrative operations. The new CEO is invited to the Senior Leadership Council.

Strategic Plan 2020: Annual Accountability Session – Year 3
Patient Experience – Enhance the quality of the patient experience

Develop a framework to deliver high quality care.

The Integrated Quality Framework defines quality, an integrated quality committee structure; and, a quality improvement model with related resources and education. An Integrated Quality Framework is key to creating a culture of quality and improve quality indicators not yet meeting the target.

Hand Hygiene results are lagging and contribute to ongoing infection outbreaks. An invitation to the Public Health Organization to assess the Hospital environment resulted in recommendations including patient and family hand hygiene tactics and education to encourage use of alcohol based hand rub.

Enhance understanding and continue to grow and embed our PFCC philosophy.

Patient Satisfaction scores improved to 67.1% in Q4 and may be attributed to Patient Oriented Discharge Summaries (PODS) and patient experience action plan implementation and the introduction of phone surveys. Staff should be commended for their engagement and focus on patients, even when job demands and overcapacity are at its peak.

Advance the academic environment.

The Hospital is committed to an expansion of the simulation program and exploring fundraising opportunities with the foundation. An expanded program will improve learner satisfaction and contribute to staff development by providing an effective and safe learning environment.

The Research Institute strategic initiatives have been integrated and aligned with the Hospital initiates that pertain to research.

Invest in staff development, engagement, and wellness.

Development of the Healthy Work Environment is complete. The model and related action plan promotes the health and wellness of staff. Activities in year one will focus on enhancements within current physical environment and budget. Activities in subsequent years will require some investments.

Workplace Violence Prevention recognized as a strategic priority and integrated into the 2020 strategic plan. The Hospital developed an action plan to enhance safety in the workplace.

The 2020 Strategic Plan includes objectives to evaluate and increase the knowledge and competency of staff; and improve the sensitivity of care in the areas of acute mental health, senior's health and patient experience overall. The "Sensitivity" objective, now falls within the RESPECT Campaign, is currently rolling out education.

Use information technology to advance the patient experience.

The Northwest Health Alliance (NWHA) completed the draft business plan for an 'Advanced Clinical System. In March the NWHA hosted a workshop to discuss critical success factors for adoption including physician engagement and funding sources. An estimated $30 million investment for technology upgrade and major enhancement for safe and quality practice is required. In 2018/19, the project team will decide on the readiness and investment required for a new Health Information System (HIS).

Strategic Plan 2020: Annual Accountability Session – Year 3
Indigenous Health – Enhance culturally appropriate care

Provide care that improves self-management, access, experience, and transition to home for Indigenous patients.

New Indigenous focused cancer screening resources have been designed that describe the importance of regular screening and the locations that screening is available throughout the region. Pamphlet holders have been installed in various waiting rooms in the hospital and the resources have also been sent to nursing stations across the region. The Indigenous Navigators have been coached on how to talk to their patients about screening and provide additional information when requested.

Provide health care that respects traditional knowledge and practices, and builds TBRHSC as a leader in the provision of health care for Indigenous patients.

Focus on Indigenous Health has demonstrated the need for additional resources to address disparities in health status between Indigenous and non-Indigenous people in our region. The process to create and fill a permanent Senior Director, Indigenous Collaboration was initiated in Q4. Reporting to the President and CEO, this person will be responsible for forging and nurturing relationships and advising the Senior Leadership Council on strategies.

The Indigenous Health & Reconciliation Steering Committee (IHRSC) met on March 16 and finalized the Terms of Reference. The Committee addresses challenges with Indigenous Health disparities and barriers to equitable access to service for Indigenous patients at the Hospital. The IHRSC focuses on systemic and service advances through partnership and advocacy for funding. Examples of the steering committee activity include helping to prioritize Indigenous Health research priorities, facilitate partnerships, and consult on policies.

Strategic Plan 2020: Annual Accountability Session – Year 3
Mental Health – Enhance acute mental health service

Adopt attitudes and behaviours that recognize mental health as an integral part of the delivery of comprehensive acute care services.

This objective is now encompassed within the RESPECT Campaign, which launched this year and will roll out across the organization over the next two years.

Enhance the delivery of mental health care to all patients at TBRHSC, outside of mental health services.

A new program, called the Consultation Liaison Service (CLS) was designed and is in the pilot phase. The CLS provides psychiatric consult for off-unit mental health patients to ensure any mental health concerns are appropriately monitored. Dr. Hampe started the CLS Pilot on 1A In-Patient Unit in December and provided consultation to 64 patients, of which 14 were transferred to the Adult Mental Health Program for additional Inter professional team support.

In addition, a safe room checklist was developed and rolled out to all inpatient units. The checklist provides staff the tools to make off-unit mental health patient environments safer, quiet and respectful.

Collaborate with system partners and appropriate governing agencies to develop and enhance transitions in care.

A formal governance structure regarding allocation of psychiatrists at the Hospital is in the final stages with St. Joseph's Care Group.

Enhance the delivery of acute mental health care within mental health.

A transition specialist was hired to assist with Child and Adolescent Mental Health patients' transition back to community, arrange necessary follow up care and communicate with all members of the health care team. Further, a new discharge sheet and checklist was implemented and outlines requirements for Adolescent Psychiatric patient discharges from the paediatric unit was implemented. This resource ensure off-service mental health patients receive the appropriate supports on discharge.

Strategic Plan 2020: Annual Accountability Session – Year 3
Seniors' Health – Enhance the care provided to an aging population

Deliver an optimal experience for seniors

A medical directive for urinary incontinence was developed to allow the nurses to removed Foley catheters when it is longer medically required, which will improve timelessness of patient care. The directive is expected to be implementation in 2018/19.

Adopt the Ontario Senior Friendly Hospital Framework

The Research Ethics Board (REB) conducted a review to determine whether seniors participating in research are sufficiently protected. It was found the Hospital is compliant with the national standards and upholds the principles, respect for persons, concern for welfare and justice. To further protect seniors participating in research, the Hospital's REB recommends:

1. Develop guidelines to recruit, consent, and include or exclude seniors in research;
2. Develop strategies for research clinicians to define and assess vulnerable seniors' to participate in research.

A literature review of best practices for seniors' Advanced Care Planning was completed and reviewed by the Ethics Committee in consultation with Patient and Family Advisors. The recommendations developed will ensure patients' values and wishes are respected in the formulation of their goals and care plans. Implementation is expected in 2018/19.